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'I can do the child no good': Dr Sims and the Enslaved Infants of Montgomery, Alabama

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Summary. This article examines the influence of slavery and race on medical education, practice and research in the American South. Drawing on the published autobiography, case-histories, and correspondence of American slave surgeon and 'pioneer' gynaecologist, James Marion Sims, the contribution highlights a lesser known episode from his early career, namely his surgical treatment of enslaved infants suffering from trismus nascentium (neonatal tetanus). Sims became a highly prestigious figure in his later medical career, but the foundations of his success relied on the use of slave bodies and enslaved patients. These were typically distinctive features of the life of an ambitious medical professional in the slave South, where the profession profited from the institution of slavery, and human experimentation and medical research were advanced specifically through the exploitation of the region's enslaved population.

Keywords: James Marion Sims; slavery; American South; enslaved body; anatomy; human experimentation

> My doctrines in respect to the pathology and treatment of trismus nascentium have not been adopted by the profession at large, but I am satisfied that they are true.[1]

The life-story of James Marion Sims (1813–83), surgeon and 'pioneer' gynaecologist, is a widely known one and is currently the subject of intense interest among feminist scholars, historians of slavery and medicine and political activists who wish to reshape the symbolic landscape of the American South by calling for the removal of monuments commemorating his surgical innovations.[2] Sims's career as a surgeon, almost literally a 'log-cabin to White House' tale of success, is no longer discussed solely in celebratory terms.[3] His numerous innovations and experiments attract more attention today because of a concern for the health and welfare of the patients subjected to his surgical forays, rather than their status as uncomplicated landmark moments in the triumphal rise of scientific medicine. Recent readings of Sims challenge his reputation as the altruistic founder of modern operative gynaecology by drawing attention to the fact that he based his breakthrough discoveries on experiments that he conducted on—among

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[1]Sims 1884, p. 222.

[2]For feminist readings of Sims's career, see Axelson 1985; Barker-Benfield 1976; Daly 1978; McGregor 1987, 1989 and 1998; Ojanuga 1993. For Sims in social histories of medicine and slavery, see Boney 1984; Dally 1991; Savitt 1982. For debates about Sims's legacy and the Sims memorials, see Gray 2000, Lerner 2003, and Spencer 2006.

[3]See Sims 1881, 1884; Harris 1950.

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others—enslaved women forced to submit to the most invasive and often harmful procedures.[4]

This article examines a lesser known episode from that which Sims described in his autobiography as his 'memorable era'—the period between 1844 and 1849, when he 'perfected' his famous cure for vesico-vaginal fistula.[5] It is based on the published accounts of his 'Observations' and interventions on enslaved infants suffering from trismus nascentium, now known as neonatal tetanus. Today, neonatal tetanus is understood to be a form of generalised tetanus caused by environmental exposure to the bacterium, *Clostridium tetani*. The condition is usually precipitated by infection of the unhealed umbilical stump. Symptoms appear from three to ten days after birth and include trismus—a spasm of the jaw muscles or lockjaw—clenched fists, excessive flexion of the toes, stifled cry, and an inability to suck. Once infection occurs, the condition is often fatal. Preventive medicine through the use of vaccines, combined with hygienic care of the new-born, are the most effective solutions.[6] Trismus nascentium figured as a common cause of death among new-borns, particularly among infants born into slavery, throughout the South in the first half of the nineteenth century.[7] Southern slave-owners, whose economic well-being depended on the successful reproduction and survival of their enslaved labour force, regarded the disease with particular concern.

Sims's case-histories and autobiographical reflections, as well as comments by his biographers and critics, offer important insights into both the character of antebellum Southern medicine and the impact of slavery on the medical treatment of those enslaved in the system. Steven Stowe's recent *Doctoring the South* argues that a 'country orthodox style', which reflected close ties between 'ordinary physicians' and 'the knowledge and morality of their communities', marked the defining characteristic of mid-nineteenth-century Southern medicine.[8] By contrast, this article emphasises the influence of anatomy and clinical medicine on Southern health care, and the impact of these practices on the region's slave population, as key features of antebellum Southern medicine. While the history of experiments on enslaved Southerners has received some attention by medical historians, the important example of Sims's medical education and early surgical career requires more detailed analysis.[9] This article emphasises the routine and commonplace nature of the dissection and vivisection of vulnerable slave bodies, and how such practices became intimately connected to the construction and maintenance of privileged medical and social identities in the antebellum South. While Sims may have been exceptional in gaining international medical celebrity, the use of slave cadavers and enslaved patients to advance his education

[4]See Axelson 1985; Fett 2002; McGregor 1989; Ojanuga 1993; and Schwartz 2006. Kenny 2006 suggests that African-American, feminist and social historical perspectives now provide a consensus view of Sims's life and career.

[5]An accident of childbirth, appearing as a tear in the walls of the vagina, causing continual leakage from the bladder. Sims 1884, p. 209.

[6]McMillen 1991, p. 293.

[7]McMillen 1991.

[8]Stowe 2004, p. 7.

[9]Boney 1984; Fett 2002, pp. 151–3; Kenny 2003; Lederer 1995, pp. 115–16; Savitt 1982, Schwartz 2006.

and career stood as typically distinctive features of professional medicine in the slave South, highlighted in annual circulars advertising Southern medical schools, and in case-histories submitted to the region's medical periodicals.

A Southern Medical Apprenticeship

The medical education of James Marion Sims initially followed a pattern quite usual for North American physician-apprentices in the second quarter of the nineteenth century. Sims's career began when his father, with some reluctance, arranged for him to train under a preceptor, local physician Dr Churchill Jones, uncle of Sims's future wife, Eliza Theresa Jones, of Lancaster, South Carolina, in February 1833.[10] Sims admired Churchill Jones's surgical abilities and from him 'imbibed a desire to distinguish [himself] in surgery'.[11] Gert Brieger has suggested that the system of medical apprenticeship fitted well with the instruction of surgery, as '[b]andaging, dressing changes, and care of skin lesions all presented opportunities for the apprentice to learn', and acquire 'the basic skills needed by the surgeon'.[12] While such practical experience came as an essential and unexceptional component of any rural doctor's basic training, for Sims it also marked an early movement towards specialisation and a style of medicine that emphasised active intervention and use of the scalpel.

Despite all the potential benefits and opportunities of apprenticeship under a preceptor, in the first half of the nineteenth century an ambitious American doctor's career became increasingly dependent upon a course of college medical education.[13] For a would-be surgeon, this was indispensable. Only within the setting of a medical school or a hospital could a student acquire and develop the necessary knowledge of and skill in practical anatomy. Michael Sappol has noted that in its North American setting, anatomy 'provided the physician with real advantages in his competition with midwives, folk healers, clergymen, and other physicians', and thus turned into a means by which to claim 'epistemological, healing, and cultural authority'.[14] In the United States, the centrality of practical anatomy in medical education also helped prepare the ground for the importation of Parisian clinical methods in the 1830s and 1840s. The adoption of the French Clinical School's new ways of visualising and examining diseases further reinforced the importance of anatomy, with the autopsy room rather than the library becoming 'the principal theater in which [medical students might] earn their intellectual laurels'.[15]

In November 1833, Sims began his medical education proper at the Medical College of the State of South Carolina. Having been something of a dilettante in his pre-medical student days at the South Carolina College in Columbia (now the University of South Carolina), Sims determined to 'work in real earnest' when he arrived in Charleston. He drew special attention to his anatomical training in his autobiographical account of this

[10]Sims 1884, p. 117.
[11]Ibid.
[12]Brieger 1980, p. 176.
[13]Starr 1982, pp. 3–59; Warner 1998, pp. 17–31.
[14]Sappol 2002, p. 75.
[15]Rosenberg 1987, p. 83. See also Sappol 2002; Warner 1998.

period.[16] Anatomical demonstrations and courses of dissection were a lucrative market for medical educators and practitioners in the early nineteenth century. Anatomy courses always featured prominently in circulars promoting medical colleges and 'students considered anatomical studies to be central to their medical education'.[17] Circulars issued by the inaugural faculty of Charleston's Medical College of South Carolina in 1824 support this view, emphasising both the fundamental importance of anatomy to medical education and the ease with which bodies could be obtained and dissected.

> No place in the United States offers as great opportunities for the acquisition of Anatomical knowledge, subjects being obtained from among the colored population in sufficient number for every purpose, and proper dissection carried on without offending any individual in the community. Those impediments which exist in so many other places, to the prosecution of this study, are not here thrown in the path of the Student, public feeling being rather favourable than hostile to the advancement of the Science of Anatomy.[18]

Students who decided to study medicine in Charleston did so with assurances of community support and understanding for the anatomical component of their medical education. This was in radical contrast to the public rage and protests which had been directed against Yale Medical College during that same year. In the towns and cities of the northeast, the practice of dissection, and the clandestine efforts of the medical school faculty and their students to obtain a sufficient number of bodies for that purpose, often resulted in public uproar, or what became known popularly as 'resurrection riots'.[19]

In order to gain some measure of social acceptance for the practice of dissection, nineteenth-century American anatomists plied their trade upon the bodies of outcasts and indigents of many ethnicities, together with members of the free black and slave communities. Often supplied by resurrectionists, anatomists' cadavers came from a range of fertile locations for corpses: workhouses, small family and community burial grounds, orphanages, jails, hospitals, potters' fields and public cemeteries.[20] Recent archaeological findings from the excavated site of an antebellum medical college in Augusta, Georgia, have confirmed the South's preference for using African-American corpses in medical education.[21] Similarly, the bulk of the bodies used in the world of Charleston medical education belonged to slaves. Public opinion tolerated the interregional slave trade that flourished in Southern towns and cities, and few white observers

[16] 'I worked in the dead house with interest. It was fascinating . . . I derived a practical knowledge from it . . . and know that I was doing something toward laying deeper the foundation for knowledge to come'. Sims 1884, p. 119.

[17] Sappol 2002, p. 54; see also Warner 1998, pp. 25–75.

[18] 'Circular, issued by the Faculty—on the occasion of the Medical Society of South Carolina having organized a School of Medicine in Charleston, 2nd August, 1824', Waring 1959, p. 18.

[19] Edwards 1951, pp. 178–84; Sappol 2002, pp. 117–18, 136–7; Shultz 1992.

[20] Breeden 1975, pp. 321–8; Humphrey 1973, pp. 819–27; Sappol 2002, pp. 98–135.

[21] Blakely and Harrington 1997. Breeden and Savitt's work shows a similar pattern for antebellum Virginia. Breeden 1975; Savitt 1978.

found any reason to oppose the extension of this profitable commerce in black bodies to include corpses.[22]

The social distance between master and slave facilitated the objectification and commodification of slave bodies. As Steven Stowe has explained in editing and interpreting the diary and autobiography of Southern physician Charles Hentz, the enslaved 'abounded' in the 'social world' of Southern doctors, but 'most of them were no one in particular; they were part of the world but not part of social relations'.[23] In such circumstances, Southern medicine extracted profit from slave remains and exploited the emotional space between black cadavers and white physicians to promote epistemological and professional advancement.

Surgeon to the Enslaved

Despite having gained a sound knowledge of anatomy while in Charleston and an appetite for surgery while completing his degree at Jefferson Medical College in Philadelphia, Sims made a disastrous start to his career as a general practitioner in his home town of Lancaster, South Carolina, in the summer of 1835.[24] In doing so, he exposed the limitations of a far too brief medical education, lacking in sufficient clinical experience. Rare was the early nineteenth-century American medical school that required a student's attendance for more than two four-month terms in successive years, while less common still were schools that offered hands-on clinical instruction.[25] Sims's clear inability to diagnose or offer effective treatment to his first two patients, both fatal cases of infant diarrhoea, known to the laity as 'the Summer complaint', exposed the potentially tragic consequences of such a stunted educational programme.[26]

Confronted by the shame of the deaths of both child-patients, and the frailty of his medical knowledge, Sims left Lancaster and headed west for a fresh start in the rapidly growing new state of Alabama. Following spells of residence and practice in Mount Meigs and the Cubahatchee Creek region of Macon County, Sims settled in Montgomery in 1840.[27] In his autobiography, Sims recorded that Montgomery's tiny, free black population provided the first patients to seek his services. After an initial struggle to attract enough paying patients to keep him solvent, he began to develop a lucrative 'practice among the rich people' of the city.[28] This new prosperity allowed Sims to consolidate his professional status and concentrate on forging his medical reputation. To this end, he joined Montgomery's first professional medical body, the Sydenham Medical Society, and began to exercise what he felt to be his natural gift for surgery. Seale Harris, Sims's principal biographer, mentions that up to this point in his career it

[22]On Charleston and the inter-regional slave trade in the antebellum South, see Bancroft 1996; Tadman 1996.

[23]Stowe 2000, p. 17.

[24]Sims 1884, pp. 129–38.

[25]Kaufman 1980, pp. 11–13; Rothstein 1972, pp. 89–91; Starr 1982, pp. 42–4; Warner 1998, p. 18.

[26]Sims 1884, pp. 139–45.

[27]By this time, Sims had married his childhood sweetheart, Theresa Jones—in December 1836—and had two children to support.

[28]'I had the Cromelins, the Pollards, the Balls, and others. These belonged to the upper-crust; and the fact of my being physician of these aristocratic families naturally interested others . . .'. Sims 1884, p. 207.

would have proved very difficult for him to concentrate on cultivating surgery alone: 'The custom was for every physician, whatever his aptitudes, to do a little bit of everything—and Sims was no exception.'[29] In Montgomery, however, the constraints of custom fell away as Sims exploited the opportunities that Southern slavery presented for the formation of the first in a series of specialist medical identities he would assume, that of the surgical innovator.

A medical contemporary of Sims in Montgomery, Dr W. O. Baldwin, recalled in detail some of the earliest steps Sims took to establish one of the largest surgical practices in Alabama.[30] After reading newspaper accounts of the 'sensation' created by Dr Hugh Huger Toland in his home state of South Carolina, with successful operations to correct club-foot and cross-eyes, Sims made a bold assault on similar cases in his own locality.[31] Obtaining new eye instruments and rehearsing steps outlined in medical journals, Sims 'was not long in finding cases of each of these unseemly deformities upon which to try his skill'.[32] These operations, described by Seale Harris as 'carried out largely by instinct and based on what might be termed mail-order instructions', were completely unheard of in this section of the southwest. However, the success of these procedures brought Sims instant local fame.[33] So abundantly did similar cases present themselves that within two years Baldwin boasted that Sims 'had about finished up and straightened all the cross-eyes and club-feet within forty or fifty miles of Montgomery'.[34] Sims had discovered that he possessed the essential pre-anaesthetic traits of 'swift-moving fingers' and 'split-second resourcefulness'.[35] Furthermore, he had awakened his own 'ambition for surgery' and determined to perform 'all sorts of beautiful and brilliant operations'.[36]

Important fundamental changes in the organisation of his Montgomery practice allowed Sims to take advantage of any opportunity to further his surgical career. First, in the corner of his Perry Street office-yard, Sims erected a ramshackle, eight-bed hospital, later expanded to 16 beds with the addition of a second storey, which he set aside almost exclusively for the care of 'negro surgical cases'.[37] In this environment, with his slave patients subject to his close and constant medical supervision, Sims took liberties that helped to develop his skills in anatomical and surgical science. Indeed, his autobiography boasts that in this most 'memorable era' of his life, 'there was never a time that I could not, at any day, have had a subject for operation'.[38] Here he performed some of the most dangerous, yet personally and professionally significant, of his surgical operations.

As Reginald Horsman has noted in his biography of Southern physician and racial theorist Josiah Clark Nott of Mobile, Alabama; 'Clinics or infirmaries that devoted at least part

[29]Harris 1950, p. 73.
[30]Baldwin 1884, pp. 425–48.
[31]Baldwin 1884, p. 427; Waring 1967, p. 311.
[32]Baldwin 1884, p. 428.
[33]Harris 1950, p. 74.
[34]Baldwin 1884, p. 429.
[35]Harris 1950, p. 74.
[36]Sims 1884, p. 209.
[37]Sims 1884, p. 230.
[38]Sims 1884, pp. 209, 241.

of their space to blacks were common in the South in these years.'[39] Slave hospitals first became a standard feature of low-country plantation estates, where masters responded not only to the need for a conveniently located facility devoted to general slave health and welfare, but also to the recurrent threat of epidemic fevers among larger slave populations.[40] As the medical profession grew in synchronisation with the development of urban centres in the South, newspapers and periodicals published by entrepreneurial physicians and proprietary medical schools promoted numerous private infirmaries for the care of slave-patients.[41] In addition to seeking financial gain, a number of these same Southern medical men clearly aimed to use their private hospitals as experimental and educational facilities to further both medical knowledge and individual reputations.[42]

Perhaps the most infamous of these experimental slave infirmaries in the antebellum era was Dr T. Stillman's Medical Infirmary for Diseases of the Skin, located at 110 Church Street in Charleston. Stillman advertised his hospital in the *Charleston Mercury* in October 1838, which closed with the following notice:

> TO PLANTERS AND OTHERS—Wanted fifty Negroes. Any person having sick Negroes, considered incurable by their respective physicians, and wishing to dispose of them, Dr S. will pay cash for Negroes affected with scrofula or king's evil, confirmed hypocondriasm, apoplexy, diseases of the liver, kidneys, spleen, stomach and intestines, bladder and its appendages, diarrhoea, dysentery, &c. The highest cash price will be paid on application as above.[43]

This newspaper advertisement was discovered by the militant anti-slavery abolitionist, Theodore Dwight Weld (1803–95), and included as an example of Southern slavery's 'barbarous inhumanity' in his compilation of 'facts and testimony', *American Slavery as it is: Testimony of a Thousand Witnesses* (1839).[44] Sims, like Stillman, was one of the new breed of ambitious Southern clinicians; his investment in building slave health-care facilities paid immediate dividends, as his practice grew yet more profitable and he was able to attract 'all sorts' of interesting new cases.[45]

As he developed an extended reputation as an accomplished surgeon, Sims came to the attention of young men in the area who wished to enter the medical profession. Throughout his years in Montgomery, Sims added to his income by offering his services as preceptor to a number of students, who in turn assisted him in some of his most daring surgical operations.[46] He further capitalised on his local fame as a busy and energetic young practitioner by using the first four-wheeled doctor's buggy ever seen in the district. His 'Grecian galley', driven by a 'Negro boy', one of several slaves he owned, enabled him to drive rapidly through the city and out into the plantation districts. Older physicians

[39]Horsman 1987, pp. 130, 131.
[40]Vlach 1993, pp. 144, 145.
[41]Waring 1967, pp. 17, 18.
[42]Horsman 1987, p. 131.
[43]*Charleston Mercury*, 6 October 1838.
[44]Weld 1839, p. 171.
[45]Sims 1884, p. 209.
[46]Sims 1884, p. 234; Harris 1950, p. 86.

customarily travelled their rounds on horseback or in an old-fashioned two-wheeled sulky. Sims, however, recognised the necessity for speed in order to assure of his arriving first on the scene of accidents and emergencies.[47]

With the theatre, props and cast now assembled, Sims had only to bring his medical productions to a larger audience. Sims, who claimed to have always made notes on his surgical cases, demonstrated that he understood the value and power of establishing a literary identity when he published a short account of an 1844 'Operation for Double Congenital Harelip' in the *American Journal of Dental Science*.[48] This first article was 'discovered' on Sims's bookshelf by an influential and prosperous Montgomery medical colleague, Dr Silas Ames—'Montgomery's acknowledged medical leader' and the town's 'most eminent medical writer'.[49] Ames praised Sims's 'natural. . . description of the case' and advised him to report more of his 'beautiful' and 'difficult' operations 'for the press'.[50] With the encouragement and editorial advice of Dr Ames, Sims began to select and compose 'the histories' of his surgical cases for submission to medical periodicals. In this effort to establish a wider reputation, a majority of the experiments conducted by Sims in the development of new surgical procedures reported utilising the bodies of the enslaved.[51] A slave-holder himself, as well as being a medical practitioner, Sims consciously exploited the South's system of political economy, which permitted the use of slave labour to generate personal fortune and express cultural capital, in order to advance his own claims for social and intellectual legitimacy.[52]

Trismus, Treatment and Tragedy

Discussion of trismus nascentium appears in some of the South's earliest medical periodicals, and a number of theories circulated as to its origin.[53] For example, Charles W. Capers, writing in the *Carolina Journal of Medicine, Science and Agriculture* in 1825, listed a variety of causes to which this disease, 'so well known' and to which 'Negro children are much more liable', had been ascribed:

1st. To cold.
2d. To smoke.
3d. To retention of the meconium.
4th. To confined air.

[47] Baldwin 1884, p. 444.
[48] Sims 1844.
[49] Harris 1950, pp. 78–9.
[50] Sims 1884, p. 216; Harris 1950, p. 79.
[51] An equal number of white and slave cases are reported by Sims in the seven articles listed, but only his slave patients are subject to surgical intervention and post-mortem investigation.
[52] Walter Johnson notes of southern slave-holders that 'their selves were built out of slaves', and, in the case of some Southern physicians, 'the slaves themselves were to be the slaveholders' work' in pursuit of an enhanced 'reputation as a healer'. Johnson 1999, pp. 102, 115, 116.
[53] McMillen 1991, p. 293. See also Postell 1951, p. 83; Kiple and King 1981, pp. 75, 101–4; Savitt 1978, pp. 120–2.

5th. To dividing the funis umbilicalis [umbilical cord] in an unproper manner; and
6th. To the ulceration which succeeds the falling of the funis.[54]

With hindsight, it is clear that from early in the century many slave-owners and Southern physicians correctly identified the condition's origin in the improper handling and subsequent infection of the umbilical stump. However, slave-owners and physicians also often blamed the condition on the intervention of 'ignorant Negro midwives'. The duties of midwifery often fell to 'unskilled' slave women because of the exorbitant fees charged by trained *accoucheurs*.[55] Furthermore, as Kiple and King suggest, many of the problems Southern doctors strove to recognise as neonatal tetanus could in fact have been caused by calcium deficiency, or tetany, a disease that exhibited similar symptoms and could easily be mistaken for trismus.[56]

James Marion Sims's thoughts and practices, however, in respect of the cause and treatment of infant 'lock-jaw' differed markedly from those of the laity and medical profession at large.[57] This can be explained in a variety of ways. His actions could be seen to mark the beginnings of a change in the medical thinking of the period, at the very moment at which American surgery was developing a more localistic, anatomic and experimental approach. Sims's professional writings also mark a significant stage in the evolution of the American surgical profession and mirror its efforts to gain a legitimate foothold in the medical market-place. Finally, as a Southerner, Sims endorsed an emergent regional and racially inflected medical opinion, of both practical and political importance. Slavery defined African-Americans as a separate and subordinate social group and, increasingly from the 1840s, Southern medical opinion made significant contributions to the vigorous defence of the South's 'peculiar institution'.[58] Southern physicians not only asserted black anatomical and physiological inferiority in theoretical terms, but also carried these beliefs into their medical encounters with slaves and evidenced distinctly different ethical and therapeutic practices in a significant number of their recorded case-histories involving slave patients. A close focus on Sims's treatment of slave infants reveals the influence of slavery and race in determining antebellum medical behaviour and decision-making, as well as the role of race and slavery in the creation of medical knowledge in this period.

Sims's first recorded observations and experiences with neonatal tetanus helped shape his understanding of the condition from both a slave-holder's and a physician's perspective. At the close of his first article on 'Trismus Nascentium—Its Pathology and Treatment' published in 1846, Sims recalled the loss of 'a little negro seven days old of this disease' in 1838.[59] This was at a time when Sims and his wife were struggling to make a living in the

[54]Capers 1825, pp. 60–4.
[55]Kiple and King 1981, p. 169; Fett 2002, pp. 45, 51; Schwartz 2006, pp. 180–3.
[56]Kiple and King 1981, pp. 101–4. See also McMillen 1991 for the range of theories offered in explanation of trismus by the Southern medical profession.
[57]McMillen argues that Sims was the 'first individual to stir controversy' in the great trismus debate. McMillen 1991, pp. 304, 305.
[58]This 'contribution' has been described as 'states-rights medicine'. See, for example, Breeden 1976; Duffy 1957, 1968; Marshall 1940/41; Sawyer 1988; Warner 1983, 1985.
[59]Sims 1846, p. 378.

then malaria-plagued Cubahatchee Creek region of Macon County, Alabama, and they would have felt strongly the financial loss of the infant's future labour and sale value.[60] His second encounter with trismus occurred in November 1839, just a few days after the birth of his second child, Eliza. Sims's infant daughter demonstrated the tell-tale signs of 'violent spasms, with her tiny arms and legs as rigid as pokers and her skin a cold mass of clammy perspiration'.[61] With his limited medical experience, Sims failed to offer either a diagnosis or suggest a remedy for the child. Quite by accident, however, his wife, Theresa, seemed to hit upon the solution:

> Instead of placing the infant on its back, as she usually did, she inadvertently put it on its side. Within a little while the young Eliza began to show signs of returning health, and a few hours later her alarming symptoms had quite disappeared and she was apparently as well as ever.[62]

This experience helped Sims to formulate his standard professional guidance for parents to guard against this distressing infant malady; 'A new-born child especially should be placed upon a pillow, lengthwise of the pillow. If this were done always, there would be no cases of trismus nascentium.'[63] But as Sims's own published case-notes on the disease indicate, both his advice and methods of treatment were not always so simple or cautious, particularly when the case involved a child born of slave parents.

In his autobiographical reflections, Sims recalled that he treated his first case of the then fatal condition in April 1845, practising in Montgomery, Alabama. A local planter, Henry Stickney, had called 'to say that his negro woman, Sally, had recently been confined with twins, and that one of them was very ill . . .'. Inspired more by scientific interest than by confidence in his ability to administer relief, Sims agreed to take the case; 'I can do the child no good; but, as a study, I will come out to see it and investigate the case.' He arrived and found the child near death; 'the whole body was rigid . . . . Its face was drawn . . . . Altogether the picture was a disagreeable one to look upon'.[64] Sims examined the child's head, which, following the normal mode of pathogenesis after the introduction of bacillus into the body, would have been severely contracted, especially around the jaw and neck muscles, and located what he later diagnosed as the 'exciting cause' of all the symptoms: 'The occipital bone was pushed under deeply on the brain, and the edges of the parietal bones.'[65] But Sims was still unable to bridge the gap between his observations and an effective therapeutic response, and the child died. After a detailed post-mortem examination, at which he recalled having invited the attendance of nine fellow Montgomery medical colleagues, Sims 'elaborated a very

[60]When Sims moved to New York in 1853, he and his wife made plans to sell the 'dozen negroes' they owned. Sims 1854 in Sims Papers 1835–84; Sims 1884, pp. 265–6.

[61]Harris 1950, p. 69. See also Sims 1848, pp. 18–19.

[62]Harris 1950, p. 69.

[63]Sims 1884, p. 225.

[64]Sims 1884, pp. 222, 223.

[65]Sims listed three 'mechanical causes' of trismus; 'the *predisposing*, being protracted or tedious labour . . . particularly, a too well ossified state of the foetal cranial bones. The *exciting* cause is undue pressure on these bones . . . the *immediate* cause . . . undue compression of the medulla oblongata and the nerves originating from it'. See Sims 1848, p. 30.

ingenious theory' that suggested the pressure on the child's brain resulted from 'spinal hemorrhage'.[66] Confident of his thesis on trismus and eager to enter into print, Sims submitted his findings from the case of Sally's child to the leading medical periodical of the time, the *American Journal of the Medical Sciences*.

Although he failed to offer a cure for Sally's baby, Sims encountered more cases of trismus nascentium, and built up a substantial body of case-notes on the condition. For at around this same time, his practice and his reputation as a surgeon grew at a rapid pace. In order to cope with growing numbers of slave patients sent to him by the outlying plantation owners too far removed from town to benefit from his daily rounds, Sims took the unusual step of building a small private hospital in the back-yard of his Montgomery home.[67] Here Sims conducted a series of operations on slave patients—men, women and children—which solidified his reputation as both a surgeon and a specialist in gynaecology. These formidable and exhausting medical interventions, performed before the adoption of anaesthesia, became trials of strength and will for doctor and patient alike. The operations were also characteristic of their time in that the main surgical technique Sims adopted was resection—the cutting-away of growths, tumours and other anomalies. What these early cases also clearly demonstrate is the degree to which Sims, as a Southern physician, depended on slave 'clinical' material to further his career and develop his skills as a surgeon. Furthermore, Sims's decision to specialise in surgery had important implications for his treatment of slave patients suffering from trismus.[68]

In 1848 Sims published a fourth contribution to the *American Journal of the Medical Sciences*, his heavily revised 'Further Observations on Trismus Nascentium'. In this article, Sims outlined a general theory on the condition, asserting that the disease was:

> of centric origin, depending upon a mechanical pressure exerted on the medulla oblongata and its nerves . . . the result, most generally, of an inward displacement of the occipital bone, often very perceptible, but sometimes so *slight* as to be detected with difficulty . . . when it persists for any length of time after birth, it becomes a pathological condition . . . relieved simply by rectifying this abnormal displacement, and thereby removing pressure from the base of the brain.[69]

This explanation of trismus, with the emphasis on 'mechanical' causes and anatomical irregularities—'abnormal displacement'—deliberately brought the condition within the realm of Sims's medical expertise and understanding, that of surgery. In remarking that the 'displacement' of the bones of the crania he had examined in infants thought to be suffering from trismus was 'sometimes so *slight* as to be detected with difficulty',

[66]As Sims's early career repeatedly illustrates, the body of a slave, dead or alive, was an opportunity to be grasped enthusiastically by an ambitious Southern physician. Sims 1884, p. 224. The 'very ingenious theory' comment appears in Sims 1884, p. 224; and the 'spinal hemorrhage' theory appears in Sims 1846, p. 366.

[67]This facility was both a clinical research 'laboratory' and a place to showcase his talents to the local medical community. Sims 1884, p. 230.

[68]Sims rehearsed many of the steps outlined in this literature before attempting his own surgical procedures. See Sims 1884, pp. 129–38, and Harris 1950, pp. 26–35, 73.

[69]Sims 1848, preface and p. 35 (emphasis in the original).

Sims both suggested the need for specialist medical knowledge and betrayed evidence of 'a class of cases' where perhaps this subtle disturbance in form was overlooked.[70] Colleagues of Sims, Drs Baldwin and Boling in Montgomery and Dr Gaillard in Charleston, certainly managed to miss such outward signs of trismus and, in fact, disagreed with both Sims's hypothesis and his methods of treatment, advocating 'the old notion of the traumatic umbilical origin of the disease'.[71] As he would soon prove, without question, in his search for a cure to vesico-vaginal fistula, Sims remained determinedly single-minded in the face of professional criticism.[72]

The use of enslaved people for medical and surgical experimentation in the South during the antebellum period was both common and widespread.[73] This is evident not only in Sims's gynaecological experiments on enslaved women and similar experiments conducted by his professional rival Nathan Bozeman, but also, as the recent work of Marie Jenkins Schwartz has demonstrated, in the many trial procedures developed for the treatment of menstrual irregularities among enslaved women and experiments intended to ensure and enhance fertility.[74] An examination of the case-histories in 'Further Observations' with Sims in attendance, offers yet more evidence of medical experiments on the enslaved and discloses clear differences across racial lines in his handling of neonatal tetanus. With white infant sufferers, such as the baby daughter of Wyatt Peters, Sims, his social and professional reputation at stake, demonstrated extreme caution. Not 'giving any medicine' and, perhaps recalling his wife's 'domestic remedy', he simply 'had the child placed properly on its side on a pillow …'.[75] When the child afflicted came from the slave population, however, Sims showed a willingness to perform surgical interventions that drew on his more abstract anatomical observations.

In Case V of Sims's 'Further Observations', which reflected on an incident from April 1846, Dr Vickers, a friend and colleague of Sims, was summoned to treat a 'negro child' at Robert T. Ashurst's plantation.[76] The child had great difficulty feeding and had been sick for four or five months—'more or less all its life'. Finding the child incapacitated by involuntary muscular contractions—'a regular gyration'—Vickers initially placed the child on its side and in 'one hour the spasmodic action … began to subside'. But, it then occurred to Vickers to indulge in some speculative physical investigations, 'with the view of observing the symptoms of … a trismal character'. This involved aggravating and reproducing the painful paralysis, by pressurising the parietal and occipital bones. Vickers occupied himself in this way 'for nearly half an hour … alternately producing and relieving the symptoms of *lock-jaw*; in the first instance by *displacing* the occiput and, in the next, by *replacing* it'.[77] Having ascertained his ability to artificially induce the spasms, Vickers was about to leave when 'Mrs A', the plantation mistress, appeared and insisted that the doctor administer 'a good big dose of calomel' to the child. Vickers,

[70]Sims 1848, p. 10.
[71]Sims 1848, p. 10. See also McMillen 1991, pp. 308, 309.
[72]See Harris 1950, pp. 91, 92; and Sims 1884, p. 242.
[73]Boney 1984; Fett 2002; Kenny 2003; Lederer 1995; Savitt 1982.
[74]Schwartz 2006, pp. 67–106.
[75]Case IV in Sims 1848, pp. 4, 5.
[76]Case V in Sims 1848, pp. 6–9.
[77]Case V in Sims 1848, p. 8 (emphasis in the original).

not wanting to complicate his experiments with the mercurial effects of the nation's favourite domestic purgative, prescribed a placebo (of prepared chalk)—an ingenious means of disguising his own mechanical meddling.[78]

Eleven days later, Vickers returned with Sims, who wanted 'the satisfaction of fully verifying' these 'observations on the trismal symptoms in connection with the displaced occiput'. Sims saw that the child's cranial bones were still 'movable by pressure', and through 'the use of considerable force', succeeded in emulating Vickers by again displacing the occiput:

> What was my surprise to see, in an instant, the immediate reproduction of the involuntary gyrations of the *right* arm and leg with a motionless state of the opposite side. This experiment was often repeated, with precisely the same results. Each time, as the pressure was removed, the symptoms ceased, the bone resuming its position with the cessation of the pressure.[79]

The heightened scientific curiosity of these two doctors would have been diminished considerably had their young patient been the child of Mrs A. Of all the reports on trismus presented in Sims's two articles, the only cases in which he performed surgical interference or a post-mortem were those cases involving enslaved infants. Southern physicians not only discussed experimental procedures involving non-white subjects with virtual impunity in the pages of the region's medical journals, but also conducted clinical research on plantations through experimentation on slaves. The power of medical science in the South was not confined solely to a central complex of institutions located in the region's major towns and cities; rather, it was extended and dispersed through the wider web of the disciplinary mechanism and relations that constituted Southern slavery.

As a busy and trusted physician to a number of slave-holders in Montgomery, Sims found himself in a position that allowed him to pursue his interest in slave infants afflicted with trismus, to develop his theory on the condition, and to test the effectiveness of a surgical approach to its relief. Indeed, in his first article on the condition he claimed to 'have accumulated a host of this sort of case', while in his 'Further Observations' he added 'I have examined the heads of several hundred infants, since my mind has been turned to the investigation of this subject.'[80] In January and February 1847, a slave-holder requested Sims to examine the children of two 'negro' women, Ann and Frances, whose new-born babies exhibited typical trismal symptoms. (They were 'unable to suck' and 'jumping' in 'clonic spasms' [violent and rapidly successive muscular contractions and relaxations].)[81] He took full advantage of the simultaneous presentation of two slave infant cases of trismus to apply his experimental surgical approach.

In the case of Ann's baby son, 'having tried the experiment of laying the child in every position possible' and finding that this 'had a decided tendency to aggravate all

[78]Ibid.

[79]Ibid. (emphasis in the original).

[80]Sims 1846, p. 379; Sims 1848, p. 12. In his two trismus articles, Sims provides evidence of 27 cases. Ten are narrative reports on cases provided by physician colleagues, slave-owners, and enslaved women in Montgomery, while the remaining 17 are from Sims's own case-notes.

[81]Cases XII and XIII, in Sims 1848, pp. 24–30.

the prominent symptoms', Sims concluded the case 'would become chronic' and 'retained' the child at his own home, so that he 'might watch it the more carefully'.[82] Sims also recognised an opportunity to confirm his observations and 'determined to puncture the scalp, and elevate the depressed edges of the parietals, if it should become necessary'. In an initial 24-hour observation, he refrained from surgical intervention, the child apparently improving to such an extent that Sims felt confident in sending him home 'with proper directions for … management'. Nine days later, however, on a return visit to Sims, the child presented 'a most aggravated form of the disease'. The child exhibited clonic spasms now 'frequent' and 'severe', with jaws locked and limbs 'all in a state of rigid demiflexion'. Sims 'looked upon the case as almost hopeless'. Yet, 'as a matter of experiment' and in hope of reducing the tonic, or rigid, contractions, he 'punctured the scalp … with the point of a short strong knife, and, making a lever of it, pryed out slightly the … edge of the parietal bone …'.[83] The crude puncture resulted in 'a very severe attack of clonic spasms' and gross disfigurement of the child.

Unwilling to wait 'to see the effect of the operation', Sims sent the child home 'immediately', evidently satisfied that the 'surgery' had relieved the child's facial tension, and allowed for more freedom to be nursed and move normally. In a lengthy coda to this particular case-history, Sims revealed typical regional and professional traits in blaming both the slave mother and a slave nurse for aggravating the condition. Sims reported that Ann, the mother, was observed by her mistress, a Mrs Somerville, to have always carried the child with its head resting on her arm. He claimed that 'the constant pressure of the mother's hard arm' accounted for the 'abnormal displacement' of the infant's parietal bone. Furthermore, according to Sims, the nurse was 'not a very intelligent negress', and had carried out his instructions as to the correct positioning of the child following the first visit 'loosely and carelessly'.[84]

As part of his post-operative monitoring of Ann's offspring, Sims disclosed that he 'would occasionally puncture the scalp over the lamboidal suture, with the point of a crooked awl, and prize out the edges of the parietal bones … with the effect of greatly modifying the rigid flexures of the extremities'. This operation, 'simple and safe' in Sims's opinion, 'was frequently performed' over a two month period.[85] As in the case of the slave infant at Robert T. Ashurst's plantation, Sims appeared fascinated by his power to induce, manipulate and control the painful symptoms of paralysis associated with trismus. Such observations confirmed his physiological explanation that saw mechanical pressure on the infant's 'medulla oblongata' (brainstem) 'and the nerves originating from it' as the '*immediate* cause' of the condition.[86] Whether compressing the bones of the infant's skull forcibly by hand, or levering the bones into a new position with instruments through an incision at the base of the skull, Sims worked 'to justify the conclusion that trismus nascentium' resulted from 'mechanical causes'.[87]

[82] Sims 1848, p. 26.
[83] Ibid.
[84] Sims 1848, p. 27.
[85] Sims 1848, p. 28.
[86] Sims 1848, p. 30 (emphasis in the original).
[87] Ibid.

Sims performed a similar operation on Frances's baby. On this particular visit to the plantation he took the precaution not only of warning the slave mother of the dangers 'of supporting the child's head on her arm', but also of the possibility that he might have to operate 'on the bones of the head' should the symptoms become chronic. After he failed to relieve the child of the tonic rigidity and breathlessness characteristic of the trismal condition through his standard method of correct positioning, Sims became more emboldened as death appeared certain. Quickly turning the child on its stomach, he punctured its scalp with 'a crooked awl ... and prized out the edge of the parietal bone'.

> This produced a general spasm—then another—and another—and a gasping respiration, the eyes flying open—all resembling very much the effects of electricity suddenly applied to a body just dead. The other side of the head was punctured, and, in like manner, the edge of the other parietal bone was pushed out. The breathing improved; indeed, became regular. The ... rigidity of the extremities returned. The jumping spasms were re-established, and the child was resuscitated.[88]

Tragically, despite further 'punctures and prizings', the child died. Sims, however, found some solace in the situation. He wrote sentimentally of easing the infant's passage into the after-life:

> It did not die as children usually do of this disease—with violent agonizing, asphyxiating throes, but its strength gradually failed, and its life flickered away gently, almost imperceptibly. It lived twelve hours after elevating the depressed edges of the parietal bones, having been sick, in all, about three days.[89]

Still convinced at this point that 'spinal hemorrhage' had 'caused death in this disease', Sims obtained permission to conduct an extensive post-mortem examination on Frances's child. In his report, he made special mention that the umbilicus had 'healed up beautifully', perhaps ruling out anticipated criticism of his rash acts from those who still supported 'the old notion' of the origin of trismus. On discovering the 'perfectly bloodless' post-mortem appearance of the child's 'brain' and 'spinal marrow', however, he was forced to 'relinquish' the 'spinal hemorrhage' theory proposed in his 1846 article.[90] The weight of the physiological 'facts' outlined in his 'Further Observations' pointed to 'mechanical causes', and Sims issued detailed instructions in practical anatomy for any reader who sought proof of this new hypothesis; 'Let any one who feels curious on this point, procure a recent foetal head'.[91]

Conclusion

Despite the death of Frances's child, Sims later celebrated the memory of this campaign of crude experiments as his 'first great discovery in medicine'.[92] By practising surgical interference in cases of trismus nascentium among slave new-borns and encouraging others

[88]Sims 1848, p. 29.
[89]Sims 1848, p. 30.
[90]Sims 1848, pp. 30, 32.
[91]Sims 1848, p. 31.
[92]Sims 1884, p. 226.

to test his methods through post-mortem experiments, Sims not only advocated an expansion of the surgeon's role, but also demonstrated that the cause of experimental medicine in the antebellum South could be advanced through the exploitation of the region's subject slave population.[93] Sims's early published case-histories from his 'memorable era' in Montgomery, and his later autobiographical reflections, offer important insights into both the highly racialised character of antebellum Southern medical science, and the impact of deeply ingrained racial prejudices on the delivery of health care to the enslaved. Human experimentation developed in a social and cultural context that posed few challenges to medical research that used enslaved subjects. Indeed, Southern medicine's use of black bodies was one of the principal means through which the region's doctors learned their trade, communicated medical knowledge and gained their wealth and status. Legally defined as chattels personal in the region's slave codes, black bondswomen and men were always both property and persons in the eyes of white society. By using powerful and specialised anatomical ways of thinking about illness and injury, antebellum Southern physicians reframed and further objectified and commodified slave bodies within the context of a professionalising medical world that was becoming increasingly dependent on anatomical and clinical material.

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[93] At the close of his first article on trismus, Sims declared: 'The truth or falsity of these views can be easily tested, and New Orleans is the place to do it. . . . They have the field for observation and the facilities for post-obit dissections.' Sims 1846, p. 378.

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